

		FOR OFFICE USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0035998</u> Facility Name: <u>Mount Vernon Countryside Manor</u> Address: <u>606 New Fairfield Road</u> <u>Mt. Vernon</u> <u>62864</u> <div style="text-align: center;">Number City Zip Code</div> County: <u>Jefferson</u> Telephone Number: <u>(618) 242-1800</u> Fax # <u>(618) 242-1878</u> IDPA ID Number: <u>37-1239928-1</u> Date of Initial License for Current Owners: <u>05/09/1990</u> Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2000</u> to <u>12/31/2000</u> and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>Compilation Report Attached</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>J. Terry Dooling, Partner</u></td> </tr> <tr> <td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u></td> </tr> <tr> <td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>		Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>Compilation Report Attached</u> (Date) _____	(Print Name and Title) <u>J. Terry Dooling, Partner</u>	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u>	(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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In the event there are further questions about this report, please contact: Name: <u>J. Terry Dooling</u> Telephone Number: <u>(618) 465-7717</u>																																			

SEE ACCOUNTANTS' COMPILATION REPORT

DPA 3745 (N-4-99)

IL478-2471

[Print Preview](#)

Facility Name & ID Number Mount Vernon Countryside Manor# 0035998 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>33</u>	Skilled (SNF)	<u>33</u>	<u>12,078</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>68</u>	<u>24,888</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,966</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>896</u>	<u>656</u>	<u>6,749</u>	<u>8,301</u>	8
9	SNF/PED					9
10	ICF	<u>16,786</u>	<u>9,101</u>		<u>25,887</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,682</u>	<u>9,757</u>	<u>6,749</u>	<u>34,188</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.48%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?
60 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☒ NO ☐H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 05/09/1990J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 24 and days of care provided 6749Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2000 Fiscal Year: 12/31/2000
* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2000 Ending: 12/31/2000
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	121,633	7,319	5,756	134,708		134,708	0	134,708		1
2	Food Purchase		126,872		126,872		126,872	(1,940)	124,932		2
3	Housekeeping	71,393	13,136		84,529		84,529	1,569	86,098		3
4	Laundry	64,553	12,742		77,295		77,295	0	77,295		4
5	Heat and Other Utilities			72,151	72,151		72,151	679	72,830		5
6	Maintenance	43,595	85,274	1,122	129,991	5,539	135,530	19,167	154,697		6
7	Other (specify):* Sanitation			3,299	3,299		3,299	0	3,299		7
8	TOTAL General Services	301,174	245,343	82,328	628,845	5,539	634,384	19,475	653,859		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000	0	6,000		9
10	Nursing and Medical Records	1,046,040	58,096	3,791	1,107,927		1,107,927	(117)	1,107,810		10
10a	Therapy		2,150	558,857	561,007		561,007	0	561,007		10a
11	Activities	29,333	2,684	3,194	35,211		35,211	0	35,211		11
12	Social Services	30,551			30,551		30,551	0	30,551		12
13	Nurse Aide Training			3,496	3,496	(932)	2,564	0	2,564		13
14	Program Transportation		3,707		3,707		3,707	0	3,707		14
15	Other (specify):*							0			15
16	TOTAL Health Care and Programs	1,105,924	66,637	575,338	1,747,899	(932)	1,746,967	(117)	1,746,850		16
	C. General Administration										
17	Administrative	81,743	15,933	175,000	272,676	(4,060)	268,616	(88,020)	180,596		17
18	Directors Fees							0			18
19	Professional Services			19,751	19,751		19,751	(1,793)	17,958		19
20	Dues, Fees, Subscriptions & Promotions			9,125	9,125	2,248	11,373	(2,274)	9,099		20
21	Clerical & General Office Expenses	36,347	13,361	16,502	66,210	355	66,565	34,336	100,901		21
22	Employee Benefits & Payroll Taxes			179,866	179,866	(4,082)	175,784	14,046	189,830		22
23	Inservice Training & Education					120	120	0	120		23
24	Travel and Seminar			3,061	3,061	812	3,873	60	3,933		24
25	Other Admin. Staff Transportation							1,490	1,490		25
26	Insurance-Prop. Liab. Malpractice			39,971	39,971		39,971	1,213	41,184		26
27	Other (specify):*							0			27
28	TOTAL General Administration	118,090	29,294	443,276	590,660	(4,607)	586,053	(40,942)	545,111		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,525,188	341,274	1,100,942	2,967,404		2,967,404	(21,584)	2,945,820		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			123,332	123,332		123,332	10,695	134,027			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes			3,065	3,065		3,065	661	3,726			33
34	Rent-Facility & Grounds			6,000	6,000		6,000	(6,000)				34
35	Rent-Equipment & Vehicles			720	720		720	0	720			35
36	Other (specify):*							0				36
37	TOTAL Ownership			133,117	133,117		133,117	5,356	138,473			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		153,687	19,630	173,317		173,317	(25)	173,292			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			55,450	55,450		55,450	0	55,450			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		153,687	75,080	228,767		228,767	(25)	228,742			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,525,188	494,961	1,309,139	3,329,288	0	3,329,288	(16,253)	3,313,035			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 STATE OF ILLINOIS Report Period Beginning: 01/01/2000 Page 5
Ending: 12/31/2000
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(121)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,819)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(697)	17		18
19	Entertainment				19
20	Contributions	(100)	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,788)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,025)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,758)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,639)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,947)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,306)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35) (sum of SUBTOTALS	\$ (1,306)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (16,253)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Mount Vernon Countryside Manor

0035998 Report Period Beginning:

01/01/2000

Ending:

Summary A

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary	Operating Expenses												SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I		
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,940)	0	0	0	0	0	0	0	0	0	0	(1,940)	2
3	Housekeeping	0	1,569	0	0	0	0	0	0	0	0	0	1,569	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	679	0	0	0	0	0	0	0	0	0	679	5
6	Maintenance	(2,421)	21,588	0	0	0	0	0	0	0	0	0	19,167	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,361)	23,836	0	0	0	0	0	0	0	0	0	19,475	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(117)	0	0	0	0	0	0	0	0	0	0	(117)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(117)	0	0	0	0	0	0	0	0	0	0	(117)	16
C. General Administration														
17	Administrative	(997)	(87,023)	0	0	0	0	0	0	0	0	0	(88,020)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,361)	3,568	0	0	0	0	0	0	0	0	0	(1,793)	19
20	Fees, Subscriptions & Promotions	(2,477)	203	0	0	0	0	0	0	0	0	0	(2,274)	20
21	Clerical & General Office Expenses	(3,758)	38,094	0	0	0	0	0	0	0	0	0	34,336	21
22	Employee Benefits & Payroll Taxes	0	14,046	0	0	0	0	0	0	0	0	0	14,046	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	60	0	0	0	0	0	0	0	0	0	60	24
25	Other Admin. Staff Transportation	0	1,490	0	0	0	0	0	0	0	0	0	1,490	25
26	Insurance-Prop.Liab.Malpractice	0	1,213	0	0	0	0	0	0	0	0	0	1,213	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(12,593)	(28,349)	0	0	0	0	0	0	0	0	0	(40,942)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,071)	(4,513)	0	0	0	0	0	0	0	0	0	(21,584)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mount Vernon Countryside Manor

0035998

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	2,149	8,546	0	0	0	0	0	0	0	0	0	10,695	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	661	0	0	0	0	0	0	0	0	0	661	33
34	Rent-Facility & Grounds	0	0	(6,000)	0	0	0	0	0	0	0	0	(6,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,149	9,207	(6,000)	0	0	0	0	0	0	0	0	5,356	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(25)	0	0	0	0	0	0	0	0	0	0	(25)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(25)	0	0	0	0	0	0	0	0	0	0	(25)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(14,947)	4,694	(6,000)	0	0	0	0	0	0	0	0	(16,253)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 Land Lease	\$ 6,000	Jerry King	100.00%	\$	\$ (6,000)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 6,000			\$	\$ *	(6,000) 39

Sum_6A

-6000

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6D

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number Mount Vernon Countryside Manor # 0035998 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerry King	Owner	Mgmt/Consultant	100.00%	127,509	16	26.89%	Salary	\$ 46,895	17,8	1
2	Denise King	Regional Director	Administrative	0.00%	99,811	13	26.89%	Salary	36,708	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00%	54,155	11	26.89%	Salary	19,917	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00%	92,288	0	0.00%	Salary	0	N/A	4
5	Elizabeth King	Dietary	Dietary	0.00%	2,496	0	0.00%	Salary	0	N/A	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00%	4,387	1	26.89%	Salary	1,613	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 105,133		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Mount Vernon Countryside Manor# 0035998

Report Period Beginning:

01/01/2000Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

King Management Company

Street Address

935 Mill Street

City / State / Zip Code

Nashville, Illinois 62263

Phone Number

(618) 327-3064

Fax Number

(618) 327-3083

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	127,091	4	\$ 5,835	\$ 5,835	34,173	\$ 1,569	1
2	5	Utilities	Patient Days	127,091	4	2,526		34,173	679	2
3	6	Maintenance	Patient Days	127,091	4	80,286	74,072	34,173	21,588	3
4	17	Administrative	Patient Days	127,091	4	327,191	316,921	34,173	87,977	4
5	19	Professional Fees	Patient Days	127,091	4	13,268		34,173	3,568	5
6	20	Dues, Fees & Subscriptions	Patient Days	127,091	4	755		34,173	203	6
7	21	Clerical & Office Expense	Patient Days	127,091	4	141,674	113,988	34,173	38,094	7
8	22	Employee Benefits	Patient Days	127,091	4	52,239		34,173	14,046	8
9	24	Travel & Seminar	Patient Days	127,091	4	225		34,173	60	9
10	25	Other Admin Transport.	Patient Days	127,091	4	5,541		34,173	1,490	10
11	26	Insurance	Patient Days	127,091	4	4,510		34,173	1,213	11
12	30	Depreciation - Other	Patient Days	127,091	4	9,414		34,173	2,531	12
13	30	Depreciation - Vehicles	Direct Cost	1	1	3,875		1	3,875	13
14	30	Depreciation - Vehicles	Patient Days	127,091	4	6,622		34,173	1,781	14
15	30	Depreciation - Copier	Direct Cost	1	1	359		1	359	15
16	33	Property Taxes	Patient Days	127,091	4	2,460		34,173	661	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 656,780	\$ 510,816		\$ 179,694	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Schedule Not Applicable						\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	3,300	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	3,115	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(185)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	3,250	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	3,065	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1995	2,810	8
1996	2,863	9
1997	2,966	10
1998	3,080	11
1999	3,115	12

FOR OFF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

Line 2: Real Estate Taxes paid are for the 1999 tax year **Line 7: \$3,065 Real Estate Tax Expense**

Line 4: Accrual is based on 1999 taxes paid **661 Home Office Allocation**

3,726 Total Real Estate Ta

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories One

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Residential Living Center is a 37 unit, 28,000 square foot assisted living facility located on the property adjacent to Mt. Vernon Countryside Manor

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1988	\$ 95,254	1
2	Home Office		1989 & 1995	1,691	2
3	TOTALS			\$ 96,945	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

0035998

Report Period Beginning:

01/01/2000 Ending:

Page 12

12/31/2000

Facility Name & ID Number Mount Vernon Countryside Manor

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1990	1990	\$ 2,725,128	\$ 90,838	30	\$ 90,838		\$ 968,819	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Landscaping			1990	26,544	878	10	878		26,544	9
10	Parking Lot			1990	26,563	892	10	892		26,563	10
11	Door and Screen			1992	1,700		10	170	170	1,445	11
12	Vanity and Medicine Cabinet			1992	1,136		10	114	114	966	12
13	Garage			1993	7,238	483	15	483		3,579	13
14	Water Heater			1995	2,960	197	15	197		1,118	14
15	Smoke Detectors			1996	812	81	10	81		406	15
16	Air Conditioners - 2			1996	1,342	268	5	268		1,297	16
17	Multiflow Furnace/Condensing Unit			1996	1,541	308	5	308		1,387	17
18	Storage Building Roof			1996	5,100	510	10	510		2,380	18
19	Asphalt East Parking Lot			1996	2,373	237	10	237		1,068	19
20	Air Conditioners - 2			1996	1,549	310	5	310		1,291	20
21	Entry Control System			1996	1,133	113	10	113		567	21
22	Vinyl Floor Covering			1996	4,465	447	10	447		2,009	22
23	Fire Alarm System			1997	13,564	904	15	904		3,391	23
24	Furnace and Tempering Valve			1997	2,112	141	15	141		540	24
25	2 Air Conditioners			1997	1,502	150	10	150		526	25
26	Water Heater			1998	3,273	218	15	218		655	26
27	Air Freshener System			1998	1,314	132	10	132		383	27
28	Air Freshener System			1998	1,300	130	10	130		314	28
29	Gazebo			1998	2,974	198	15	198		496	29
30	Water Heater			1999	3,414	228	15	228		360	30
31	Water Heater			1999	2,429	162	15	162		256	31
32	Carpet			2000	9,666	161	10	161		161	32
33	Flooring			2000	18,661	156	10	156		156	33
34	Concrete Pad for Gazebo			2000	4,303	0	15	167	167	167	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
					\$ #VALUE!	\$ 98,142		\$ 98,593	\$ 451	\$ 1,046,844	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

0035998

Report Period Beginning:

01/01/2000 Ending:

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12/31/2000

Facility Name & ID Number Mount Vernon Countryside Manor

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Home Office Parking Lot			1989	531					531	9
10	Home Office New Building			1995	26,359		25	1,054	1,054	5,447	10
11	Home Office Interior Finishes			1996	1,635		15	109	109	490	11
12	Home Office Carpet			1996	572		5	114	114	514	12
13	Home Office Cabinets			1996	905		20	45	45	204	13
14	Home Office Electrical			1996	313		15	21	21	94	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$ 1,343	\$ 1,343	\$ 7,280	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

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Report Period Beginning:

01/01/2000 Ending: 12/31/2000

Page 12B

Facility Name & ID Number Mount Vernon Countryside Manor

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Mount Vernon Countryside Manor# 0035998

Report Period Beginning:

01/01/2000

Ending:

12/31/2000**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 481,611	\$ 24,608	\$ 27,622	\$ 3,014	4-10	\$ 416,050	37
38	Current Year Purchases	5,970	582	813	231	5	813	38
39	Fully Depreciated Assets	23,031					23,031	39
40								40
41	TOTALS	\$ 510,612	\$ 25,190	\$ 28,435	\$ 3,245		\$ 439,894	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Home Office	1996 Chrysler Concord	1995	\$ 6,641	\$	\$ 0	\$	4	\$ 6,641	42
43	Facility	1993 Dodge Caravan	1993	15,738		0		4	15,738	43
44	Home Office Vehicle	1998 Ford F150 Truck	1997	7,122		1,781	1,781	4	5,638	44
45	Facility	1999 Ford Escort	1999	15,500		3,875	3,875	4	6,781	45
46	TOTALS			\$ 45,001	\$	\$ 5,656	\$ 5,656		\$ 34,798	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 123,332	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 134,027	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 10,695	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,528,816	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Section Not Applicable	\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	Section Not Applicable	\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ N/A YES ☐ N/A NO16. Rental Amount for movable equipment: \$ 720

Description:

Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section Not Applicable</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current
rental agreement:

Fiscal Year Ending

Annual Rent

12. /2001 \$ _____13. /2002 \$ _____14. /2003 \$ _____* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Mount Vernon Countryside Manor

#

0035998

Report Period Beginning:

01/01/2000

Ending:

12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☒ YES
☐ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☒

HOURS PER AIDE

403. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☒

HOURS PER AIDE

80

B. EXPENSES

ALLOCATION OF COSTS

(d)

	1	2	3	4
	Facility			
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$ <u>1,890</u>	\$	\$ 1,890
2 Books and Supplies	<u>69</u>	<u>304</u>		373
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments				
8 Nurse Aide Competency Tests		<u>301</u>		301
9 TOTALS	\$ 69	\$ 2,495	\$	\$ 2,564
10 SUM OF line 9, col. 1 and 2 (e)	\$ 2,564			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>6</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>1</u>
2. From other facilities (f)	
TOTAL TRAINED	7

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a,3	hrs	\$	8,581	\$ 175,348	\$	8,581	\$	175,348	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		5,079	146,705		5,079		146,705	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a,3 & 10a,2	hrs		12,117	236,804	2,150	12,117		238,954	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39,2	# of prescripts				153,687			153,687	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Lab, X-Ray Other (specify): & Ambulance	39,3					19,630			19,630	13
14	TOTAL			\$	25,777	\$ 558,857	\$ 175,467	25,777	\$	734,324	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 124,273	\$	1
2	Cash-Patient Deposits	8,875		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,294,541		3
4	Supply Inventory (priced at)	7,040		4
5	Short-Term Investments			5
6	Prepaid Insurance	47,626		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	250		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,482,605	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,866,958		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	480,286		16
17	Accumulated Depreciation (book methods)	(1,466,575)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	54,018		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(54,018)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	13,205		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,893,874	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,376,479	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 196,777	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,875		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,018		30
31	Accrued Taxes Payable (excluding real estate taxes)	68,262		31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,250		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 336,182	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 336,182	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,040,297	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,376,479	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Print Preview

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,430,275	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,430,275	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	995,022	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(385,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 610,022	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,040,297	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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STATE OF ILLINOIS

Page 19

Facility Name & ID Number Mount Vernon Countryside Manor

0035998

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,112,375	1
2	Discounts and Allowances for all Levels	324,633	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,437,008	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	884,231	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 884,231	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,512	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,512	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,559	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,559	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,324,310	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	\$ 628,845	31
32	Health Care	1,747,899	32
33	General Administration	590,660	33
	B. Capital Expense		
34	Ownership	133,117	34
	C. Ancillary Expense		
35	Special Cost Centers	173,317	35
36	Provider Participation Fee	55,450	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,329,288	40
41	Income before Income Taxes (line 30 minus line 40)**	995,022	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 995,022	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Print Preview

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,876	2,109	\$ 44,100	\$ 20.91	1
2	Assistant Director of Nursing	2,088	2,179	34,062	15.63	2
3	Registered Nurses	11,663	12,372	181,336	14.66	3
4	Licensed Practical Nurses	20,981	22,148	242,792	10.96	4
5	Nurse Aides & Orderlies	69,659	72,214	543,749	7.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,961	4,089	29,333	7.17	10
11	Social Service Workers	3,038	3,247	30,551	9.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,842	16,990	121,633	7.16	15
16	Dishwashers					16
17	Maintenance Workers	3,232	3,384	43,595	12.88	17
18	Housekeepers	11,289	11,640	71,393	6.13	18
19	Laundry	9,630	10,225	64,553	6.31	19
20	Administrator	1,851	2,218	58,617	26.43	20
21	Assistant Administrator	1,976	2,163	23,127	10.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,859	4,282	36,347	8.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,945	169,260	\$ 1,525,188 *	\$ 9.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	147	\$ 5,756	1,3	35
36	Medical Director	Contract	6,000	9,3	36
37	Medical Records Consultant	8	364	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Contract	3,202	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	68	3,194	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	223	\$ 18,516		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ Section Not Applicable		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number	Mount Vernon Countryside Manor
--------------------------------------	---------------------------------------

Report Period Beginning: 01/01/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Susan Collman	Administrator	0.00%	\$ 47,686
Marla Howard	Administrator	0.00%	10,931
Chris Wagner	Asst. Administrator	0.00%	23,127
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,744
B. Administrative - Other			
Description			Amount
Management Fees			\$ 175,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 175,000
C. Professional Services			
Vendor/Payee	Type		Amount
C.J. Schlosser & Company	Accounting	\$	11,313
Mathis, Marifan, Richter & Grandy	Legal		1,761
Duane, Morris & Heckscher	Legal		5,551
Bradley W. Small	Legal		100
Greensfelder, Hemker & Gale	Legal		1,026
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 19,751
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	33,356
Unemployment Compensation Insurance			13,823
FICA Taxes			113,934
Employee Health Insurance			10,501
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Pension			2,243
Employee Parties			1,457
Employee Physicals			470
Home Office Allocation			14,046
TOTAL (agree to Schedule V, line 22, col.8)			\$ 189,830
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
Section Not Applicable		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	200
Advertising: Employee Recruitment			3,530
Health Care Worker Background Check (Indicate # of checks performed)	119		1,428
Illinois Health Care Association Dues			2,918
Dues & Licenses			236
Subscriptions			584
Home Office Dues & Subscriptions			203
Less: Public Relations Expense		()
Non-allowable advertising		()
Yellow page advertising		()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 9,099
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			3,873
Home Office Travel and Seminar			60
Entertainment Expense		()
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	3,933

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

Print Preview

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Refinishing Wood Door	4/97	\$ 16,940	3	\$ 3,764	\$ 5,647	\$ 5,647	\$ 1,882	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 16,940		\$ 3,764	\$ 5,647	\$ 5,647	\$ 1,882	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Mount Vernon Countryside Manor

0035998

Report Period Beginning:

01/01/2000

Ending:

12/31/2000

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association - \$2,918
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 55,450
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ None Has any meal income been offset against related costs? None - N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 54.77%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.